2002-2003 Accountability Report
Transmittal Form

Agency Name: Department of Health and Human Services

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I. EXECUTIVE SUMMARY

DHHS Programs

The Department of Health and Human Services (DHHS) is responsible for administering programs funded and regulated under the following federal laws:

- ***Medicaid*** – which provides health insurance benefits for low-income families as well as the aged, blind and disabled. *Silvercard*, which provides prescription drug assistance to low-income seniors, was initiated with funds from the state's Tobacco Settlement but now operates under the Medicaid program.
- ***Older Americans Act*** – which provides funding for services benefiting those over age 65 such as Meals on Wheels, transportation and personal care services, among others.
- ***Child Care Development Fund*** – which provides financial child-care assistance for parents who are transitioning off welfare and for low-income parents who are working, furthering their education or are disabled.
- ***Social Services Block Grant –*** which provides financial assistance to critical services in areas like child and adult protection, child-care and home-based alternatives to institutional care of children and adults.

In total, these programs serve over 900,000 South Carolinians through more than 30,000 service providers and a total budget of approximately $3.7 billion with Medicaid comprising 96% of the agency's budget and functions. Non-Medicaid functions, like Aging and Child Care, make up the 4% balance and also represent the program areas in which more direct agency-beneficiary contact occurs. Because of these distinctions between the Medicaid and Aging/Child Care functions of DHHS, you will find throughout this report, particularly in the Baldrige criteria responses, some responses focus more on the Medicaid functions while others focus more on the Aging/Child Care functions.

The Scope of Medicaid

- Provides benefits for 20% of state's population
- Pays for 50% of all births
- Covers over 40% of all children
- Covers 33% of all seniors
- Pays for 75% of all nursing home beds
- Total budget of over $3.7 billion
- Accounts for 10% of General Fund budget
- Over 30 million annual claims

DHHS Leadership

Fiscal year 2002-2003 saw significant leadership transition for the Department of Health and Human Services. The year began under the administration of Governor Hodges with an agency leadership team that had been in place since shortly after Hodges' inauguration in 1999.

In November 2002, Mark Sanford was elected Governor. In the following months, the agency's senior leadership team left their positions for retirement or other opportunities. Shortly after his inauguration in January 2002, Governor Sanford appointed Robert Toomey acting director of the agency. Mr. Toomey's steady hand and wealth of state government experience was a stabilizing force during this time of transition.

In April 2003, the Senate approved the Governor's appointment of Robert M. Kerr as Director. Mr. Kerr, a Certified Public Accountant (CPA), brought 17 years' of agency experience to the position having most recently served as Chief Financial Officer (CFO). Mr. Kerr's tenure marks the first time in the history of the agency that a CPA has led the organization.

Mr. Kerr assembled his executive staff with an eye toward elevating certain functions, such as eligibility processing and information technology, to Deputy Director level attention and grouping agency bureaus in a functional fashion. For instance, the placement of the Bureau of Compliance and Performance Review under the General Counsel's supervision more closely links this fraud and abuse function with the state Attorney General's Medicaid Fraud Unit. (*See Organizational Chart on Page 9.*)

This executive leadership team immediately focused on cost-containment with line-by-line expenditure evaluation and research geared toward developing program innovations targeting specific budget lines. Also, the leadership team set about identifying disease conditions that result in significant Medicaid expenditures and developing disease management programs to actively work with these illness populations on managing their conditions with the ultimate goal of improving their quality of life while reducing Medicaid expenditures.

DHHS Mission, Vision and Values

With the new gubernatorial administration came a new executive branch mission - to raise the personal incomes of South Carolinians by creating a better environment for economic growth, delivering governmental services more openly and efficiently, improving the quality of life, and improving our state's education.

The agency's mission statement was revised to reflect the agency's support of Governor Sanford's executive mission by providing access to effective and comprehensive healthcare benefits, quality child-care services, and coordinated aging services. In fulfilling its mission, DHHS will strive to be an example of excellence to:

- ***our authorities and our fellow citizens*** – so that those who empower us believe they have received great value and that the agency has done well with that which it was entrusted,
- ***our customers*** – so that those we serve, and may potentially serve, believe they have received unparalleled service with each contact, and
- ***our employees*** – so that each believes we are making a positive difference in someone's life.

DHHS employees will do their jobs in a manner that provides our current and potential customers with service that is excellent, responsive and brings value to everyone involved. The following acronym on values is featured in our strategic planning document, the Vision Plan.

Service	We are dedicated to service; we will place others first - realizing everything we do is about those we serve – recipients and providers - and not about ourselves.
Excellence	We are committed to constant improvement and we will persevere in achieving quality with efficiency.
Responsive	We will be alert and react quickly to the needs of those we serve; we embrace innovative change – recognizing that change brings about growth.
Value	We will ensure that all of our decisions and actions are measured by the value they return; we guarantee honest, open measurements of outcomes.
Everyone	We are a team; every employee is involved in our success; we believe in servant leadership and empowering employees to solve customer problems; as a team we will encourage and hold each other accountable.

DHHS Strategic Goals

With the involvement of each agency bureau, DHHS is refining the agency's strategic goals and supporting objectives. The Strategic Plan that results from this current development process will be viewed as a living rather than static document, allowing the agency to respond appropriately to fiscal, legislative and other developments.

The overall strategic plan is still in the developmental process. However, the final strategic goals will focus on improving the following:

- the effectiveness and efficiency of the Medicaid service delivery system
- the accuracy and efficiency of the Medicaid eligibility process
- overall administrative accountability and productivity
- access to quality early child care and education
- access to programs that improve the quality of life for seniors

Key Achievements in FY 2002-2003

Eligibility Processing

- Assumed all Medicaid eligibility functions from the Department of Social Services (DSS) in July of 2002.
- Strengthened controls in the eligibility determination process in January 2003 so that:
  - except for pregnant women, initial eligibility is not triggered until actual documentation of income is received,
  - annual eligibility reviews require affirmative proof of income,
  - verification of all unearned income is required – including child support and alimony,
  - a three-month review of Low Income Families reporting no income is required, and
  - a gross income test at the time of application for Low Income Families is implemented.
- Expanded Silvercard coverage to 44,000 elderly citizens in January 2003 after receiving a federal waiver to include this population in the Medicaid program.

Medicaid Services

- Selected by the federal Centers for Medicaid and Medicare Services (CMS) to participate in an in-depth examination of selected state Medicaid and public health data linkage programs. CMS's goal is to find ways to refine collaborative data sharing arrangements among agencies and between states.
- Completed, with other state agencies, a comprehensive evaluation of therapeutic residential treatment services for emotionally disturbed children and the current data collection process. The study was partially funded by the Robert Wood Johnson Foundation and the Duke Endowment.
- Implemented Care Call, a statewide toll-free, interactive, voice response system that monitors the provision of certain in-home services to community long-term care recipients and automatically submits providers' claims for payments.
- Received federal approval to develop and implement a "cash & counseling" program that will give Medicaid community long-term care beneficiaries more control over their personal care expenditures.
- Implemented the Integrated Personal Care (IPC) program that allows enrolled community residential care facilities meeting higher than average standards to receive an additional reimbursement for providing personal care services to eligible residents.
- Received and implemented a federal grant to transition nursing home residents back into the community.

Community Services

- Participated in a national study, *Universal Financing Approaches for Early Care and Education,* to analyze the costs and impacts of alternative policy options and financing mechanisms for a quality early care and education system for young children. Private foundation support for South Carolina's participation is valued at approximately $400,000 -- an amount other states are now being charged to participate.
- Completed first year as the lead agency for child care and accomplished the following objectives in conjunction with the newly-formed and DHHS-administered Child Care Coordinating Council:
  - granted funds to the United Way of South Carolina to create partnerships that increase the affordability and availability of quality child care to working parents,
  - implemented a public-private four-year-old kindergarten pilot using existing private child-care providers to meet the needs of working parents of four-year-old children, and
  - created a public-private partnership with the agency, USC, USC foundations, the SC Department of Education, Gateway Academy, SC Educational Television, GLEAMS Head Start, and a private foundation to construct and equip a child-care Center of Excellence that will serve as a model of nationally accredited early care/education and as a research center for both the public and private sectors.

Deleted: Lead

Deleted: Agency

Senior Services

- Received the Mary Ledbetter Carolina Agency of the Year Award from the Alliance of Information and Referral Systems.
- Compiled detailed information on 4,951 public and private senior service providers to serve as the foundational components of SC Access, a database of comprehensive information, referral and assistance services for children and adults of any age with a disability, long-term illness or need.

- Completed a series of telephone surveys of seniors and their caregivers as part of the Performance Outcomes Measurement Project, an effort to develop outcome evaluation measures for the agency's senior programs. Based upon the surveys:
  - 79% of respondents receiving transportation services rated them as excellent or very good
  - 93% of caregivers surveyed rated the services as excellent, very good or good
  - 83% of respondents receiving Information, Referral and Assistance Services would recommend the services to a relative or friend
- Developed, as required by the federal Administration on Aging and based on information received from ten public hearings, a competitive procurement plan and submitted it to the federal Administration on Aging on July 1, 2003. Implementation of the plan is pending final legal notification from the Administration on Aging.

Fiscal Management and Accountability

- Expanded the scope of the agency's actuarial services contract with Deloitte and Touche to adjust managed care rates by the claim risk that may be attached to enrolled recipients.
- Added a "self-audit" process to existing fraud and abuse efforts in which providers are asked to voluntarily review their records and refund any claims overpayments, maximizing recoupments and containing in-house costs.
- Created a comprehensive compliance and performance review unit to enhance the agency's fraud and abuse efforts and thoroughly review all vendor contracts and recruited a seasoned auditor to head this unit.
- Worked with the state Attorney General's office to generate detailed Medicaid claims reports have resulted in larger fraud prosecution settlements for South Carolina.

Information Technology

- Replaced a 25-year-old eligibility processing system with the Medicaid Eligibility Determination System (MEDS) in November 2002. MEDS provides the approximately 600 eligibility workers around the state with an online, realtime system and offers greatly improved editing, date validation and automated functions. The previous system was batch oriented with little editing capabilities and required handwritten recipient notices.
- Expanded the DHHS network infrastructure to support the additional 600 eligibility staff from DSS, including the installation of Frame Relay T1 and DSL network connections.
- Installed Web Portal to facilitate staff access to email and MEDS from around the state.

Opportunities for FY 2003-2004

Viewing the current budget constraints as catalysts to change rather than impediments to improvement, the challenge for DHHS for fiscal year 2003-2004 may also be its greatest opportunity -- identifying and implementing change while continuing to provide recipients with access to quality health care. Positive programmatic change opportunities for the coming year include:

Disease Management

The Office of Disease Management is analyzing Medicaid claims data to identify costly recipient populations and develop an integrated approach that addresses these recipients' total health needs--from preventive information and self-care advice, to chronic illness management and post diagnostic counseling.

Call-In Clinical Triage Services
In an effort to avoid costly emergency room visits for non-emergent care, DHHS is piloting and exploring statewide implementation of a triage service that will provide 24/7 telephone access to a medical professional who will offer symptom assessment and provide counsel to recipients on the appropriate level of care needed for their particular situation.

340(b) Drug Pricing
To combat skyrocketing drug prices, DHHS is exploring limited use of a federal drug pricing structure that offers substantial savings over traditional Medicaid drug prices.

Counter-Detailing
Pharmaceutical manufacturers refer to their individual physician education efforts as "detailing," giving physicians the details of their drugs' chemical composition, the conditions they treat, possible side effects and the reasons their drugs are preferable. To ensure that Medicaid physicians receive unfiltered information on the many pharmaceutical choices available to them, DHHS is undertaking a significant effort to "counter-detail."

Enhanced Drug Utilization Review
DHHS is analyzing claims data to identify recipients with unusually high or duplicative pharmacy claims and then communicating with the prescribing physician about these findings. Often this cooperative sharing of information provides useful insight for the physician and positively impacts prescribing habits in the future.

Medicaid Managed Care
With actuarily re-based Medicaid managed care rates, DHHS expects that new providers of Medicaid managed care services will enter the state. This increased Medicaid managed care penetration will produce additional choices for recipients in more parts of the state and decreased overall cost to the Medicaid program for their care.

Expansion of Cash & Counseling Program
SC Choice, a "cash & counseling" program that gives Medicaid community long-term care beneficiaries more control over their personal care expenditures, will be expanded statewide from the three county pilot area of Spartanburg, Cherokee and Union counties. While the program itself is cost-neutral, studies indicate that individuals with more control over their home-care options are likely to delay admission to a more costly nursing home atmosphere.

Transportation Services
Preliminary research indicates that South Carolina is one of a handful of states in the Southeast that does not use a system of regional transportation brokers for the delivery of non-emergency transportation services. The states that do use such a system capitate these provider rates based on regional populations and, consequently, eliminate growth in the program. Additionally, the number of agency staff needed to run the program is drastically reduced as the burden of program administration is shifted to the regional transportation brokers.

Barriers for FY 2003-2004

However, very definite obstacles to the success of DHHS in capitalizing on these opportunities exist and include:

Limited Funding
Like all state agencies, DHHS is challenged by declining state revenue and mid-year budget cuts. However, the effect of cuts to DHHS is literally tripled as the loss of each state dollar means three federal matching dollars become unavailable.

Skyrocketing Health Care Costs
Throughout the country, health care costs are growing at rates significantly higher than inflation. This growth exponentially increases the pressure placed on DHHS by limited funding.

Federal Impediments to Implementation of Pharmacy Initiatives
Two significant initiatives under taken by the agency in the past fiscal year include the development of an Enhanced Prior Approval Program for prescription medication and the involvement of the state in a multi-state Medicaid pharmacy purchasing pool. As of this writing, implementation of both efforts is stalled as federal authorities continue to review them.

Carve-Out Proviso
Even with implementation of the above, current budget proviso 73.2 prohibits DHHS from including specific drugs in the enhanced prior authorization program, effectively eliminating a substantial portion of the savings the program could generate.

Changes in Certain Interpretations of Federal Law
The Medicaid administration arm of the federal Department of Health and Human Services is reviewing the methods by which public entities make Intergovernmental Transfers (IGTs) of funds and/or Certify Public Expenditures (CPEs) to state Medicaid agencies for the purpose of drawing down federal matching funds. A decision restricting or eliminating these IGTs and CPEs could pose severe hurdles to financing certain aspects of South Carolina's Medicaid program, such as disproportionate share payments to hospitals and some state agency services.

Complex System of Eligibility Categorization
In the Medicaid program, there are 28 federally-mandated eligibility categories and 21 optional categories. This system of divergent criteria for many different coverage groups makes front-line eligibility processing very difficult and complicates possible innovations in this area.

II. BUSINESS OVERVIEW

DHHS Employees and Offices

DHHS employs 1,234 full-time employees and 210 temporary grant employees for 1,444 employees in total working in the Columbia headquarters, in eligibility and community long-term care offices throughout the state, and in a child-care program monitoring office at Greenville Technical College.

DHHS Base Budget Expenditures and Appropriations

	01-02 Actual Expenditures		02-03 Actual Expenditures		03-04 Appropriations Act	
Major Budget Categories	**Total Funds**	**General Funds**	**Total Funds**	**General Funds**	**Total Funds**	**General Funds**
Personal Service	$25,121,016	$8,233,809	$38,993,611	$13,725,289	$43,122,382	$14,295,614
Other Operating	$157,856,083	$17,032,952	$171,082,554	$27,661,578	$152,013,599	$18,155,227
Special Items	$1,841,702	$1,059,950	$1,212,780	$1,050,623	$128,725,278	$1,063,252
Permanent Improvements	$525,000	$0	$0	$0	$0	$0
Case Services	$3,068,988,879	$450,918,452	$3,344,132,563	$479,426,109	$3,201,620,260	$524,160,651
Distributions To Subdivisions	$1,943,425	$150,000	$3,026,611	$0	$31,884,707	$1,034,707
Fringe Benefits	$6,936,144	$2,263,511	$11,554,351	$4,008,097	$12,074,271	$4,002,772
Non-recurring	$493,212,460	$8,466,386	$481,052,013	$3,113,963	$260,151,028	$0
Total	**$3,756,424,709**	**$488,125,060**	**$4,051,054,483**	**$528,985,659**	**$3,829,591,525**	**$562,712,223**

Other Expenditures

Sources of Funds	01-02 Actual Expenditures	02-03 Actual Expenditures
Supplemental Bills	$0	$0
Capital Reserve Funds	$0	$0
Bonds	$525,000	$0

Interim Budget Reductions

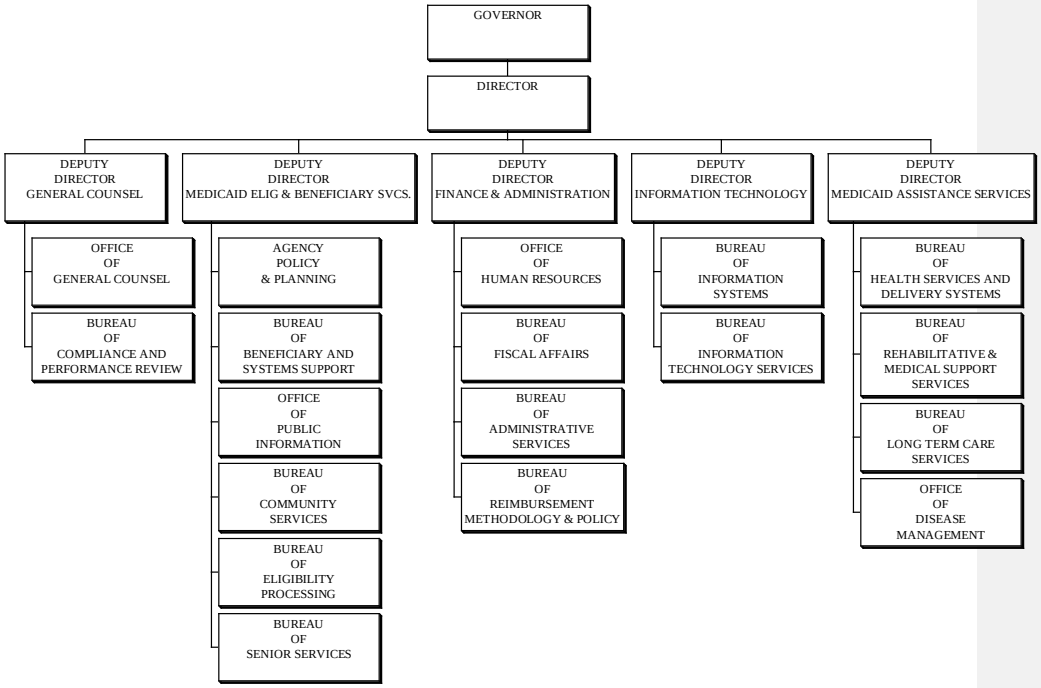
Total 01-02 Interim Budget Reduction	Total 02-03 Interim Budget Reduction
$20,869,606	$49,473,466

DHHS Key Customers, Services and Stakeholders

Services at DHHS include programs operated under Medicaid, Older Americans Act, Child Care Development Fund and Social Services Block Grant laws. The agency's primary customers include current and potential recipients and service providers. It is these individuals with whom we have daily contact that we desire to serve to the best of our ability.

However, each and every agency employee acknowledges a significant stewardship responsibility to the taxpayers for the funds this agency administers and to the Governor and the General Assembly for the responsibilities entrusted to this agency.

DHHS Organizational Structure



III. ELEMENTS OF MALCOLM BALDRIGE AWARD CRITERIA

Category 1 – Leadership

1.1(a) How do senior leaders set, deploy and communicate short/long term direction?

Executive Staff use the agency's Strategic Planning process to set, deploy, and communicate short- and long-term direction. Working with Bureau Chiefs, Executive Staff are creating an agency Vision Plan that outlines the agency's mission and values. In addition, the Vision Plan highlights DHHS Major Initiatives, each of which has an Aim or overall strategic goal, Targets or periodic goals leading to the Aim, and Outcome Measures or quantifiable results that will indicate success.

This resulting Vision Plan will be unveiled through an agency-wide E-mail, staff meetings and through the agency's monthly newsletter. Since the Vision Plan is a working document, it will be continuously discussed and refined at meetings of Executive Staff, Bureau Chiefs and their staff. As an initiative is completed, it will be removed from the Vision Plan and other initiatives will be added. Again, such modifications will be announced through agency-wide E-mails, staff meetings and through the agency's monthly newsletter.

1.1(b) How do senior leaders set, deploy and communicate performance expectations?

The Vision Plan and its component Aims and Targets set the expectations. Through staff meetings, Executive Staff communicate, reward and enforce expectations.

1.1(c) How do senior leaders set, deploy and communicate organizational values?

The Vision Plan outlines the values of the agency, and Executive Staff share them with staff.

Service	We are dedicated to service; we will place others first - realizing everything we do is about those we serve – recipients and providers - and not about ourselves.
Excellence	We are committed to constant improvement and we will persevere in achieving quality with efficiency.
Responsive	We will be alert and react quickly to the needs of those we serve; we embrace innovative change - recognizing that change brings growth.
Value	We will ensure that all of our decisions and actions are measured by the value they return; we guarantee honest, open measurement of outcomes.
Everyone	We are a team; every employee is involved in our success; we believe in servant leadership and empowering employees to solve customer problems; as a team we will encourage and hold each other accountable.

1.1(d) How do senior leaders set, deploy and communicate empowerment and innovation?

Involving bureau staff in developing and continuously evaluating the Vision Plan ensures that each employee feels ownership in the plan and empowered to implement it and suggest modifications. Additionally, recognizing Aim and Target accomplishments in Bureau Chief meetings and the agency's monthly newsletter will enhance individual empowerment.

1.1(e) How do senior leaders set, deploy and communicate organizational and employee learning?

Executive Staff recognize the need for appropriate organizational and employee learning to hone the knowledge and skills of employees, thereby improving delivery of services. State-sponsored training opportunities, like the Certified Public Managers' Program, are identified and encouraged. *(See 5.2)* Additionally, Executive Staff are establishing mandatory training in the following areas:

- supervisory skills for management staff
- customer service for all staff
- HIPAA compliance for all staff
- program specific training for designated staff

1.1(f) How do senior leaders set, deploy and communicate ethical behavior?

Ethical behavior is encouraged primarily through the following value of the agency:

Everyone — We are a team; every employee is involved in our success; we believe in servant leadership and empowering employees to solve customer problems; as a team we will encourage and hold each other accountable.

1.2 How do senior leaders establish and promote a focus on customers?

The agency values, as articulated in the Vision Plan, establish and promote a focus on customers. *[See 1.1(c)]*

Mandatory customer service training is being developed for agency staff that work directly with the public and providers. Leading by example, Executive Staff themselves talk with applicants, recipients and providers. Executive Staff are committed to helping employees help customers by first getting involved with customers themselves. The agency's toll-free numbers and Web site also help promote a focus on customers by freely providing access to agency staff and information.

1.3 What key performance measures are regularly reviewed by your senior leaders?

Executive Staff continually examine data and feedback to ascertain the financial health and mission accomplishments of DHHS.

- *Operational Performance* - utilization rates/trends, accuracy measures, eligibility accuracy reports, program integrity audits
- *Customer Performance* - customer response/efficiency reports, claims data, provider reimbursements information, eligibility efficiency reports
- *Financial Performance* - fiscal charts, budget-to-actual reports
- *Mission and Program* - strategic plan review, program specific outcome measures

1.4 How do senior leaders use organizational performance review findings and employee feedback to improve their own leadership effectiveness and the effectiveness of management throughout the organization?

Executive Staff take feedback seriously and try to respond appropriately. Regular review of the performance measures in 1.3, plus input by Bureau Chiefs and their teams, help Executive Staff assess leadership throughout the agency. Also, the Employee Performance Management System (EPMS) process, with its emphasis on employee comments and feedback, offers a tool for Executive Staff to assess management strengths and challenges.

1.5 How does the organization address the current/potential impact on the public of its products, programs, services, facilities and operations, including associated risks?

The review of key performance measures gives Executive Staff the information used to determine the impact DHHS has on the public and adjust programs/services accordingly. *(See 1.3)*

Executive Staff and Bureau Chiefs assess public impact of existing or proposed programs, or proposed changes to programs through the use of a Policy Initiative or Change Proposal review process that begins with program staff proposing the initiative or change by completing a form that includes the following questions:

- *Background* - brief description of existing condition along with reasons for change
- *Description of Proposal* - detailed narrative or proposal, includes necessary attachments
- *Evaluation/Success Criteria* - description of success criteria to evaluate the proposal
- *Fiscal Impact* - specific or itemized estimated cost or savings
- *Information Systems Impact* - changes or additions needed to automated systems
- *Beneficiary Impact* - effect on eligibles/recipients including specific estimates of additions or reductions to eligible levels
- *Provider Impact* - effect on providers including specific estimates on additions or reductions to enrollment levels and whether affected provider groups have been involved in development of proposal and their comments
- *Labor Impact* - estimated staffing requirements

- *Implementation Date/Timeline* - estimated implementation date with listing of critical interim dates and milestones

These questions ensure that program staff consider these impacts prior to formally proposing an initiative or change. Once these evaluations are complete, the Policy Initiative or Change Proposal is presented for Bureau Chief review and discussion. If approved by Bureau Chiefs, it is then reviewed by Executive Staff.

If approved by Executive Staff, the initiative or change is implemented, unless federal law requires additional review by the agency's federally-mandated Medical Care Advisory Committee. This committee is comprised of providers and recipients. In such an instance, the proposed initiative or change is presented for their review and comment prior to implementation.

1.6 How does the senior leadership set and communicate key organizational priorities for improvement?

(*See 1.1)*

1.7 How does senior leadership and the agency actively support and strengthen the community? Include how you identify and determine areas of emphasis.

The fact that the operation of this agency touches the lives of over 800,000 recipients and 30,000 providers demonstrates how Executive Staff support and strengthen the community.

Outside the task of daily agency business, Executive Staff actively support the community by participating in a number of community organizations and task forces. Additionally, Executive Staff help strengthen the community by individually supporting and encouraging agency staff to support the United Way and volunteer programs such as the Richland School District One Lunch Buddies program.

DHHS staff support the community through involvement with a myriad of health-related task forces, working groups and organizations involving strategic partners from a variety of disciplines. These include:

- South Carolina's public and private university entities like the USC Schools of Public Health and Pharmacy
- Other state agencies
- Faith-based or community service organizations like Communities In Schools, Communicare
- Foundations like the Schuyler and Yvonne Moore Foundation
- Medical professionals like physicians, dentists, pharmacists, and hospital and medical associations

Category 2 – Strategic Planning

2.1 What is your Strategic Planning process, including participants, and how does it account for customer needs and expectations; financial, societal and other risks; human resource capabilities and needs; operational capabilities and needs; and supplier/contractor/partner capabilities and needs?

(*See 1.1)*

2.2 How do you develop and track action plans that address your key strategic objectives?

Once developed, the Vision Plan will clearly identify the agency's primary Aims. Targets that will accomplish those Aims will also be clearly identified along with the bureaus designated to meet these Targets.

Staff will form working Target teams that will determine an action plan. This action plan will be reviewed and constantly monitored by Executive Staff, but the responsibility for follow-through and achievement will lie with the Target team.

2.3 How do you communicate and deploy your strategic objectives, action plans and performance measures?

(*See 1.1)*

2.4 What are your key strategic objectives? and 2.5 What's the Web address?

The agency's strategic objectives are being developed and, when complete, will be available at www.dhhs.state.sc.us. (*See 1.1)*

Category 3 – Customer Focus

(In addition to these answers, see 1.2.)

3.1 How do you determine who your customers are and what their key requirements are?

The major role of DHHS is to pay for health services provided by qualified providers with services delivered to eligible beneficiaries. Primary customers, therefore, are those who get paid (medical professionals) and those they serve (Medicaid recipients). Determining the requirements of customers happens through agency correspondence and surveys, focus group studies, review of letters/feedback to the agency, and constant communication with these customers. For applicants and recipients, primary interaction is through eligibility offices, Medicaid recipient bulletins, the agency's toll-free number and Web site. Provider representatives can meet regularly with DHHS leadership and give feedback through the Medical Care Advisory Committee (MCAC) and through interactions on task forces and in professional working groups like provider association meetings.

3.2 How do you keep your listening and learning methods current with changing customer/business needs? and 3.3 How do you use information from customers/stakeholders to improve services or programs?

DHHS keeps in touch with customers through the avenues the customers use. As more customers, both recipients and providers, move to the Internet for information, DHHS is making forms and service data available on our Web site.

DHHS tries to meet customers proactively to learn of their needs and provide adequate services. For example, to be accessible to customers on issues of importance, DHHS communicates regularly with organizations like the following:

- Healthcare-related state agencies
- Medicaid Fraud Control Unit in the SC Attorney General's Office
- The Alliance for South Carolina's Children
- The Center for Hospice and End of Life Care
- The Carolina Medical Review
- The South Carolina Health Care Association
- The South Carolina Nursing Home Association
- The South Carolina Association of Non-Profit Homes for the Aging
- The South Carolina OB Task Force
- South Carolina Medical Association Maternal, Infants, and Child Health Committee
- South Carolina Health Care Association
- South Carolina Hospital Association

Information gathered through such groups is used to continuously evaluate program operation and, as discussed in 1.5, is required prior to proposing a Policy Initiative or Change.

3.4 How do you measure customer/stakeholder satisfaction?

DHHS uses the following methods to evaluate the satisfaction of customers and stakeholders:

- surveys
- focus groups
- consumer forums
- service utilization analysis

Examples of recent surveys include:

- 94% of the respondents to a child-care survey indicated satisfaction
- 79% of respondents to a senior services survey indicated the transportation services they received were excellent or very good
- 93% of caregivers for seniors surveyed rated the services as excellent, very good or good
- 83% of senior respondents receiving Information, Referral and Assistance Services would recommend the services to a relative or friend

3.5 How do you build positive relationships with customers and stakeholders?

SERVE value guidelines from the Vision Plan – *[See 1.1(c)]*

The Director and Executive Staff are committed to an open-door policy for recipients, providers and other interested parties. Executive Staff regularly meet with customers and stakeholders to discuss concerns. Since the open flow of information and productive communication are essential to any positive relationship, the Director has streamlined the agency's procedures for responding to letters and E-mails, ensuring more timely responses to the public, legislators and the media.

DHHS produces many reports with/for customers and stakeholders to help them identify key issues and develop strategies to improve programs and outcomes. The agency's work with partners in producing these reports strengthens partnerships and promotes cooperative solutions. For example, key reports include:

- State Long Term Care Ombudsman Report to the Administration on Aging
- SC Adult Protection Coordinating Council Annual Report
- SC Quality Initiative Grant Report

The presence of DHHS employees on a variety of task forces, boards, and community groups is another way the agency builds relationships with customers and stakeholders. (*See 3.3)*

Category 4 – Information and Analysis

4.1 How do you decide which operations, processes, and systems to measure?

DHHS leadership tracks the operations, processes, and systems that show whether the agency is meeting goals and operating an efficient and effective program. Executive Staff recognize the need for these measurements and seek them by tracking major initiatives and their Outcome Measures as defined in the Vision Plan. Therefore, each time a working group plans a Major Initiative, the group identifies the Outcome Measures that will be collected.

In addition, state/federal laws require that certain aspects of programs be evaluated and program data be reported, including outcomes and profiles of processes or populations. Still other measurements may be assessed in response to special inquiries from the public, media, the Governor, General Assembly, or other interested parties.

4.2 How do you ensure data quality, reliability, completeness, and availability for decision-making?

To set the tone at the executive staff-level, the Director created a post for an Information Technology Deputy whose major responsibility it is to provide reliable data efficiently and to establish the systems to support data requests in the future. In addition, a newly-created bureau-level Office of Compliance and Performance Review will work to ensure the integrity and accuracy of the processes and services behind the data.

Other strategies to protect data quality and ensure accessibility include:

- Reviews of comparative data and investigations of variances
- Access for providers to the data system via the Web
- Internal audits
- Federal audits

The overall executive focus on improving information systems allows DHHS to provide and respond to the Governor, General Assembly, and key customers with more data for decision-making. An example of this enhanced information technology focus is the automation of the Nursing Facility and Hospital Cost Report/Rate Setting Systems.

4.3 How do you use data/information analysis to provide effective support for decision-making?

Use of key performance measures and organizational feedback, including data/informational analysis, are used to support decision-making. *(See 1.3 and 1.4)*

Quality data is the foundation of all decision-making at DHHS. The Deputy Director of Information Technology is facilitating access to the myriad of reports and statistics requested during decision-making processes. Making more specific demographic, fiscal, and programmatic-type reports available is helping planners make data-driven decisions. In addition, the agency is placing a priority focus on fiscal forecasting in programmatic planning.

4.4 How do you select and use comparative data and information?

The selection and use of comparative data is determined by the nature of any given situation. DHHS frequently uses regional and national data to compare South Carolina with other states. DHHS also uses fiscal quarter and year comparative data to identify utilization and expenditure trends for policy planning. The specific variables of service type or price, usage rates, or eligibles' demographic information define the type of report/chart/graph that is created and used.

Category 5 - Human Resource Focus

5.1 How do you and your managers/supervisors encourage and motivate employees (formally and/or informally) to develop and utilize their full potential?

Employees are motivated and encouraged through regularly-scheduled meetings with peers and supervisors, through a variety of agency training programs that are offered on an ongoing basis, and through methods of recognition which include our monthly newsletter, the *Communiqué*, and our Employee of the Month Award. Supervisors also recommend and send various agency employees to external programs such as the Certified Public Managers' Program.

5.2 How do you identify and address key developmental and training needs, including job skills training, performance excellence training, diversity training, management/leadership development, new employee orientation and safety training?

Two primary sources define the type of training available at DHHS. The first is the observation of managers and their feedback to Human Resources. Managers can recommend high-achieving employees for programs such as the Certified Public Managers' Program and the Executive Institute. And, when managers identify areas for improvement, training can be either acquired or created to respond. Secondly, a training menu offered by the State Budget and Control Board is offered to agencies. DHHS Human Resources staff can select desired training from the menu.

Occasionally, the agency has offered needs assessments to employees to determine training programs. Consultants have been brought in from time to time for the same purpose.

DHHS is currently embarking on its most aggressive training year ever, with all supervisors and managers being required to go through a mandatory management training program that will focus on several important issues including:

- Managing Employee Performance: The EPMS and Progressive Discipline
- Valuing Diversity: Strategies to Combat Sexual Harassment and Discrimination
- The Impact and Role of HIPAA at DHHS
- Conflict Management and Violence Prevention in the Workplace
- Improving Workplace Communication

Additionally, each and every employee in the agency will be required to complete Customer Service Excellence training. All new employees go through new employee orientation and are then trained at their job location by the hiring supervisor and staff.

5.3 How does your employee performance management system, including feedback to and from employees, support high performance?

Our Employee Performance Management System (EPMS) engages both the employee and supervisor to actively define, refine, and rate job performance. The process is designed to keep channels of communication open and, by documenting optional "objectives," allow for flexibility to adjust the report to accurately reflect the actual work. The EPMS is developed keeping daily job duties in focus, thereby giving the employee and supervisor goals which can be easily identified and measured. The process measures basic job functions, but also encourages employees through the rating of "performance characteristics."

5.4 What formal and/or informal assessment methods and measures do you use to determine employee well being, satisfaction, and motivation?

DHHS encourages open lines of communication among employees, supervisors and Executive Staff. All agency units are encouraged to celebrate events together. Much of this is organized agency-wide by the Employee Activity Committee (EAC), which plans events like ice cream

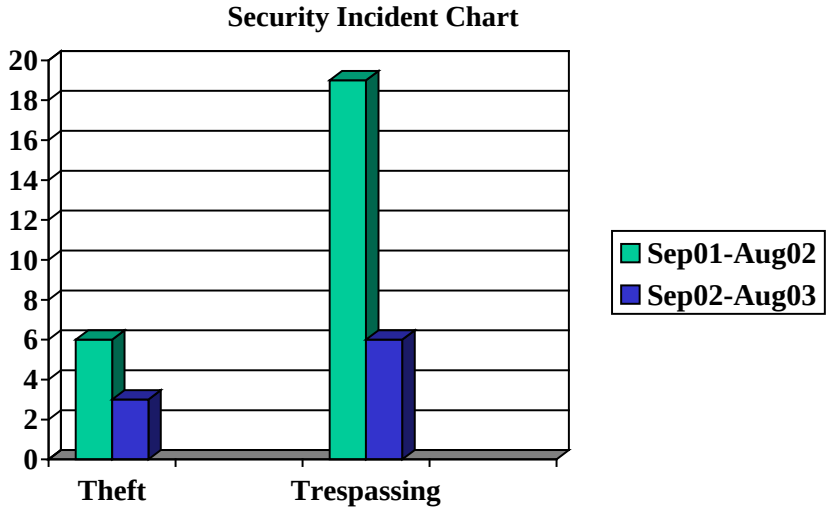
socials and holiday parties for all employees. Feedback at such functions is a key mechanism for morale measurement. In addition, an employee suggestion box is located at the main entrance to the administration building.

5.5 How do you maintain a safe and healthy work environment?

Executive Staff work to ensure a safe place for employees. Attention to the work environment is the proactive way to avoid incidences. In addition, proper handling of workers compensation claims and other reports of incidents help identify future potential issues. Leadership is regularly informed of reports and trends on safety and health issues.

In addition, DHHS has an active Employee Wellness Committee that sponsors various classes and screenings to encourage employees to monitor and promote healthy living. Activities like aerobics and yoga are available on-site during lunch hours. The Employee Wellness Committee also promotes various charitable walks throughout the Midlands to help the community and get workers involved.

The following chart is from the agency's security division. It is an example of that work unit's security measurements and tracking system and the improvements realized. DHHS security has moved to magnetized card access, security cameras, and a guard service at the main entrance to increase safety.



5.6 What is the extent of your involvement in the community?

To strengthen professional ties with the community, key customers and stakeholders, the agency encourages employee participation on a variety of boards, task forces and working groups. These groups identify key health issues and seek collaborative solutions. (*See 3.3 for a list of such key partnerships.)*

In addition, DHHS offers flexible scheduling for employees to volunteer at schools or serve on various local boards. DHHS employees are encouraged to participate in community events and bring these opportunities to the attention of their colleagues, as appropriate.

Recently, employees organized a bulletin board to support those DHHS families with active military personnel. In addition, a "Wipes for Warriors" campaign was organized to send toiletry supplies to personnel stationed overseas.

The agency's Public Health Association representatives organize efforts to support the community, most recently collecting donations for children at Palmetto Place.

Each year, the agency is a major state agency contributor to the state's United Way Campaign.

The Red Cross mobile blood collection unit makes frequent stops at the DHHS main office and employees support that agency's efforts.

Category 6 – Process Management

6.1 What are your key design and delivery processes for products/services, and how do you incorporate new technology, changing customer and mission-related requirements into these design and delivery processes and systems?

DHHS pays providers to deliver services to eligible beneficiaries. Therefore, DHHS "products" include the support of medical providers, the management of the rates they are paid, and the qualification and support of the people they serve.

Key design and delivery processes include:

- MEDS (Medicaid Eligibility Determination System) – a program to ascertain eligibility of applicants
- MMIS (Medicaid Management Information System) – the database of beneficiary demographics and usage information
- Provider contracts and enrollment agreements – the arrangements bringing providers into the system
- GAFRS – the system that manages payments to providers
- The use of external actuaries to set managed-care reimbursement rates
- PEP (Physician Enhanced Program), HMOs (Health Maintenance Organizations), HOP (Health Options Program) – various health care delivery options designed to address the various needs of beneficiaries
- Private managed care and "medical homes" – other options of care delivery for beneficiaries designed to organize all aspects of their care under one provider's management
- Disease management – the concept of proactive care initiatives to prevent adverse health issues before they arise

When new technology can simplify or speed processes, it is incorporated when possible. Recent examples of this include the new plastic "swipe-type" Medicaid card, and the voice response

verification system now available for providers to ensure accurate billing for services. Also, the Internet is allowing providers direct access to important forms and information that makes doing business easier for them.

6.2 How does your day-to-day operation of key production/delivery processes ensure meeting key performance requirements?

The key production/delivery processes identified above are all monitored at various levels. Bureau Chiefs, who work at a level that empowers them to set major initiatives yet remain close to the process, are often the staff keeping an eye on how the processes are meeting requirements. Therefore, Bureau Chiefs meet frequently with their supervisors, the Executive Staff. In addition, Bureau Chiefs meet weekly to discuss progress toward major initiatives and necessary adjustments to processes.

Executive Staff try to meet daily to keep all processes working together on agency goals. Executive Staff are constantly reviewing the processes and outcomes of the bureaus they oversee. These daily meetings allow for rapid response to intercept potential problematic issues or merge processes when cooperation will lead to better outcomes. The Director leads the Executive Staff meetings to ensure ultimate accountability of the agency to citizens.

6.3 What are your key support processes, and how do you improve and update these processes to achieve better performance?

Due to the complexity and scope of services provided by DHHS, there are a multitude of support processes. For providers, health service units support the process of recruiting health care professionals to contract with the state, follow policies, set up payment mechanisms, pursue grievances, and the like. For beneficiaries, eligibility offices ascertain the services applicants may qualify for, assist in enrolling them and may even offer counsel on health planning and healthy living.

There are processes designed to provide research support for new program development, existing program management, and state and federal legislative developments. Agency-wide, there are fiscal support services that plan and budget, reimbursement systems that ensure accurate payments, contracting and procurement divisions to support DHHS partnerships and purchasing. Other support processes include technology development and maintenance, general counsel, internal audits and external fraud investigation, and public information activity.

All of these support functions are set up as working units that will support the major initiatives of the broader bureaus. As such, the employees working in these areas use public feedback as well as internal data to provide more effective or efficient service. Bureau Chiefs and Executive Staff are empowered to restructure the personnel or funding to better align staff, make purchases, etc., to improve performance.

6.4 How do you manage and support your key supplier/contractor/partner interactions and processes to improve performance?

DHHS suppliers/contractors/partners primarily include medical and allied professionals and the people receiving the care. Many of the support processes above are designed to meet specific needs of each of these partners in their delivery or pursuit of care. Specific work units of the agency are dedicated to specific provider types and beneficiaries to help them get paid, get answers, get advice, get services, or whatever they may need. The agency has toll-free numbers for these partners and often assigns individuals to monitor the relationships. A service provider may have a representative to deal with, just as a beneficiary may have a case manager. Feedback from these partners is constantly sought through electronic and paper communications. Satisfaction surveys are used, and the agency tries to communicate clearly to the partners as changes are considered and implemented. Partners have formal grievance processes they can pursue when they contest a payment amount, or eligibility decision, and the like.

In addition, DHHS employees educate and reach out to strategic partners through educational programs and materials, various trainings, presentations and conferences. These trainings and resources support key suppliers and contractors and help DHHS work with them to improve performance and strengthen partnerships. This is a key way for DHHS to manage the myriad of partners involved in providing health care for South Carolinians. Selected partnerships include:

- Production and distribution of provider manuals for key partners
- Summer School of Gerontology
- Annual Conference on Aging
- Presentations for the Centers for Medicare and Medicaid Services
- Trainings for the Community Health Staff of Dorn VA Medical Center
- Trainings for SCHA Uniform Billing Subcommittee on alien eligibility
- Presentations for the Medicaid overview at the SC Primary Health Care Association
- Nursing Home/Community Residential Care staff training videos for the Department of Mental Health
- Production/Distribution of the SC Eden Alternative Videos
- Nearly 30 presentations by Long Term Care staff at state and national levels on issues related to community-based care
- Participation in the CMS Data Sharing Project
- Title V Training Initiative for School Districts

Category 7 – Business Results

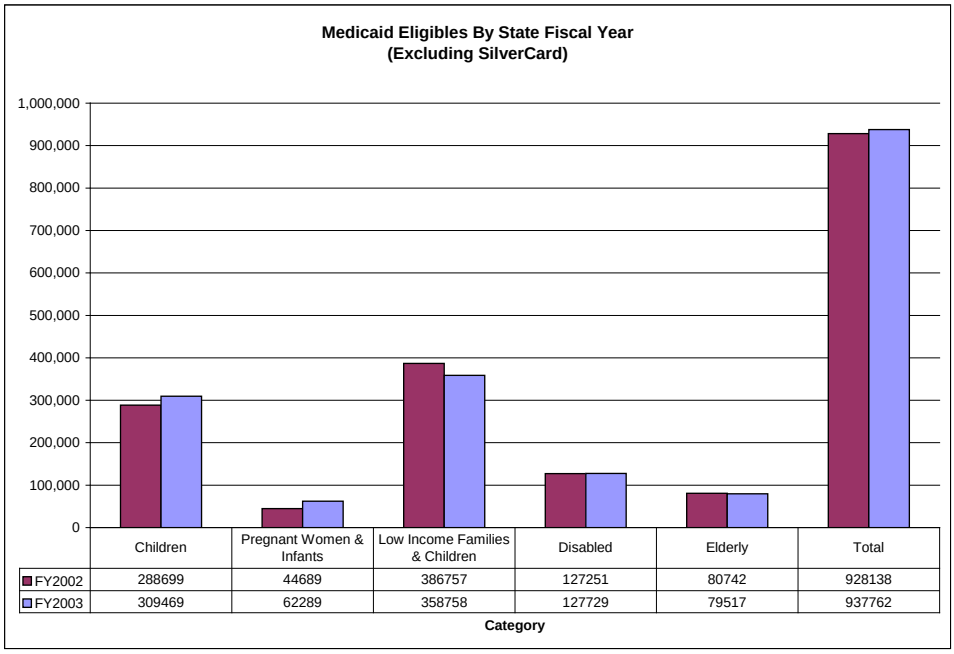
7.1 What are your performance levels and trends for the key measures of customer satisfaction?

(A sample of customer service satisfaction results is provided in 3.4.)

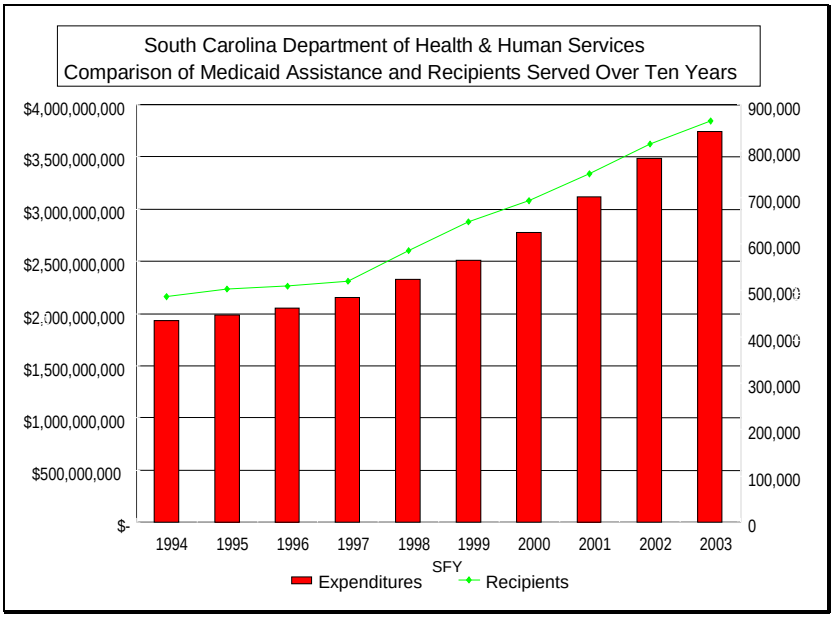
7.2 What are your performance levels and trends for the key measures of mission accomplishment?

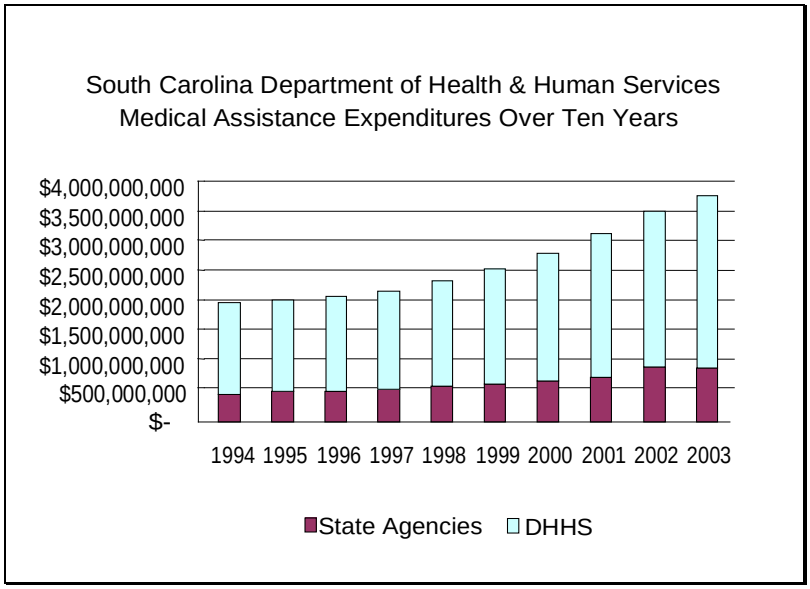
As discussed in Category 1, DHHS is in the early stage of a new Vision Plan and a new administration with its resulting structural changes. The Major Initiatives of the Vision Plan will be the measurables that will determine the levels of mission accomplishment. Trends will be identifiable over time.

The following are a few of the many charts that will aid in these measurements.



	Children	Pregnant Women & Infants	Low Income Families & Children	Disabled	Elderly	Total
FY2002	288699	44689	386757	127251	80742	928138
FY2003	309469	62289	358758	127729	79517	937762


South Carolina Department of Health & Human Services
Comparison of Medicaid Assistance and Recipients Served Over Ten Years
$4,000,000,000
$3,500,000,000
$3,000,000,000
$2,500,000,000
$2,000,000,000
$1,500,000,000
$1,000,000,000
$500,000,000
$-
900,000
800,000
700,000
600,000
500,000
400,000
300,000
200,000
100,000
0
1994 1995 1996 1997 1998 1999 2000 2001 2002 2003
SFY
Expenditures
Recipients


South Carolina Department of Health & Human Services
Medical Assistance Expenditures Over Ten Years
$4,000,000,000
$3,500,000,000
$3,000,000,000
$2,500,000,000
$2,000,000,000
$1,500,000,000
$1,000,000,000
$500,000,000
$-
1994 1995 1996 1997 1998 1999 2000 2001 2002 2003
State Agencies
DHHS

OTHER STATE AGENCY MEDICAID ASSISTANCE

	2001	2002		2003	
Department of Mental Health	154,771,202	176,915,739	14.3%	194,998,579	10.22%
DDSN	361,844,091	447,672,251	23.7%	410,939,457	-8.21%
DHEC	37,912,332	33,915,283	-10.5%	38,704,191	14.12%
Medical University of South Carolina	10,338,737	14,538,468	40.6%	27,829,341	91.42%
University of South Carolina	2,370,369	2,833,498	19.5%	5,612,272	98.07%
DAODAS	8,788,887	15,857,149	80.4%	11,839,390	-25.34%
Continuum of Care	6,371,356	8,529,603	33.9%	10,328,196	21.09%
School for the Deaf & Blind	1,325,643	1,391,696	5.0%	2,048,508	47.20%
Department of Social Services	58,176,304	60,534,139	4.1%	52,182,875	-13.80%
Department of Juvenile Justice	16,316,642	17,786,139	9.0%	23,598,126	32.68%
Department of Education	18,611,003	74,306,918	299.3%	69,965,732	-5.84%
Commission for the Blind	29,672	22,299	-24.8%	25,449	14.13%
Total Other Agency Medicaid Assistance	676,856,238	854,303,182	26.2%	848,072,116	-0.73%

7.3 What are your performance levels and trends for the key measures of employee satisfaction, involvement and development?

DHHS measures performance levels for employee satisfaction, involvement and development through the use of the Employee Performance Management System (EPMS). In addition to the EPMS, DHHS encourages the use of one-on-one and group staff meetings to address performance expectations of staff. DHHS also welcomes employee feedback through the use of the agency's employee suggestion process. All outgoing employees are given an exit interview or exit interview form to be completed, providing the agency with further insight into our agency's strengths and weaknesses. Lastly, levels of employee longevity and turnover are reviewed as an objective indicator of these performance levels.

7.4 What are your performance levels and trends for the key measures of supplier/contractor/partner performance?

Suppliers/contractors/partners (health-care professionals and the beneficiaries they serve) are not measured by DHHS on "performance." But new initiatives may help DHHS get a sense of how well the services are designed and delivered (providers) and how effective the services are, including preventive measures to avoid service necessity (beneficiaries).

Providers are being encouraged to set up "medical homes" to better manage care. This will mean that the performance of the providers should provide more effective and proactive care. This concept, combined with the disease management ideals being incorporated, should better serve and

educate beneficiaries so that their "performance" (their utilization of services and their overall health) should improve through less utilization and better health.

- Quality assurance reviews
- Contract compliance reviews

7.5 What are your performance levels and trends for the key measures of regulatory/legal compliance and citizenship?

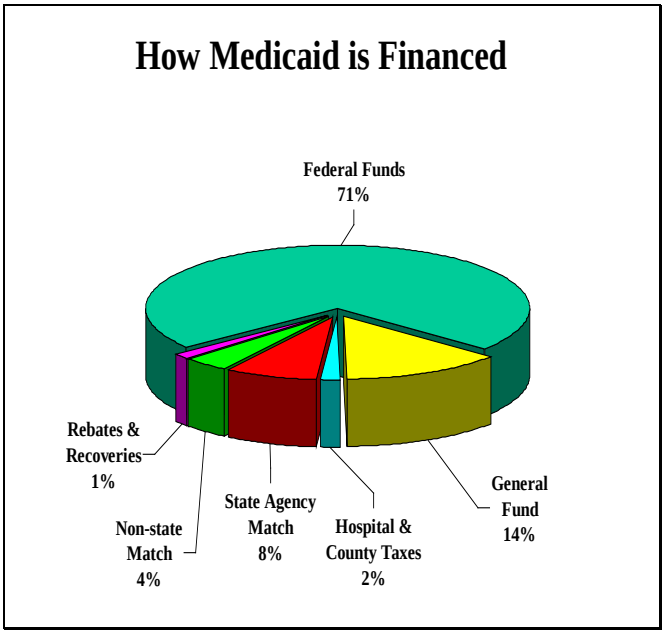
- CMS reviews/audits
- HIPAA compliance
- Internal audits/fraud detection

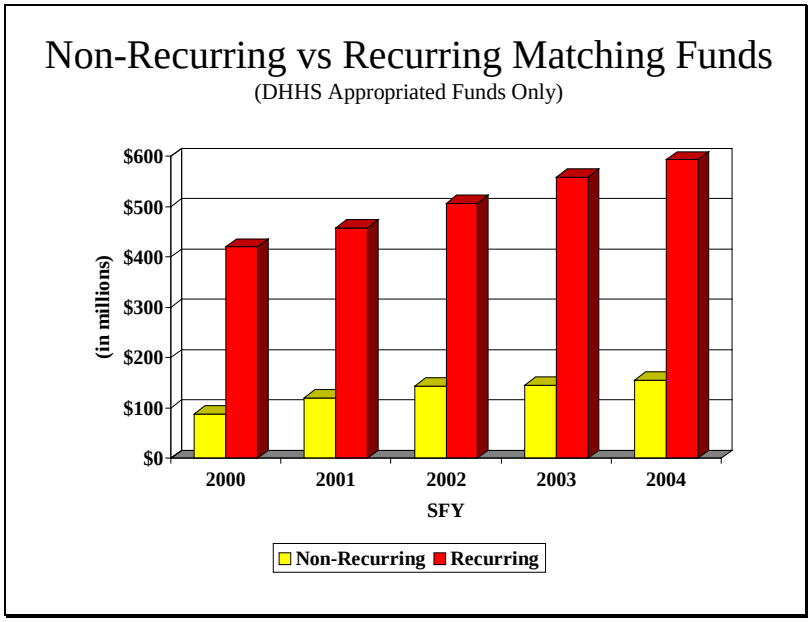
7.6 What are your current levels and trends of financial performance?

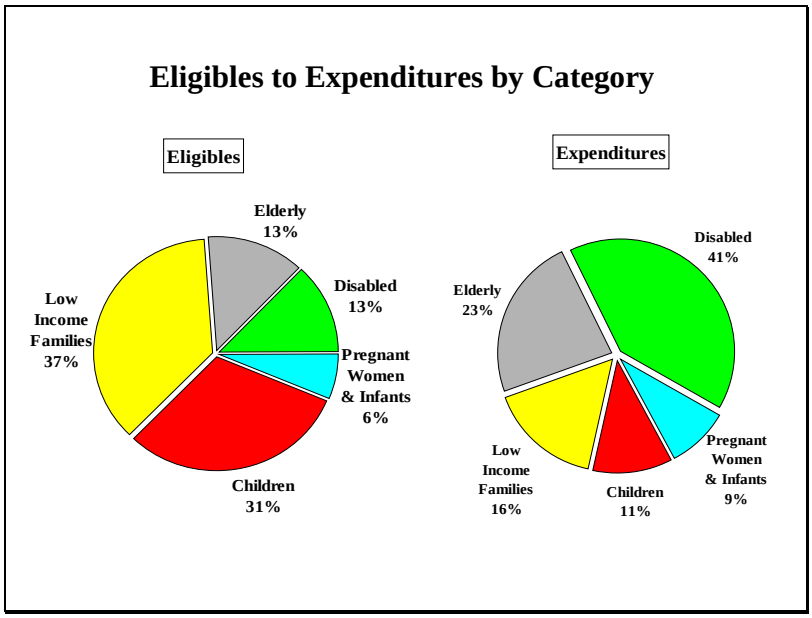
Medicaid expenditure growth has remained fairly constant at 10-12% within the last several years. Expenditure growth for FY 2003 was approximately 10%. This level of growth is consistent with more general trends in health care costs. Cost drivers include some utilization growth as well as double digit increases in drug prices.

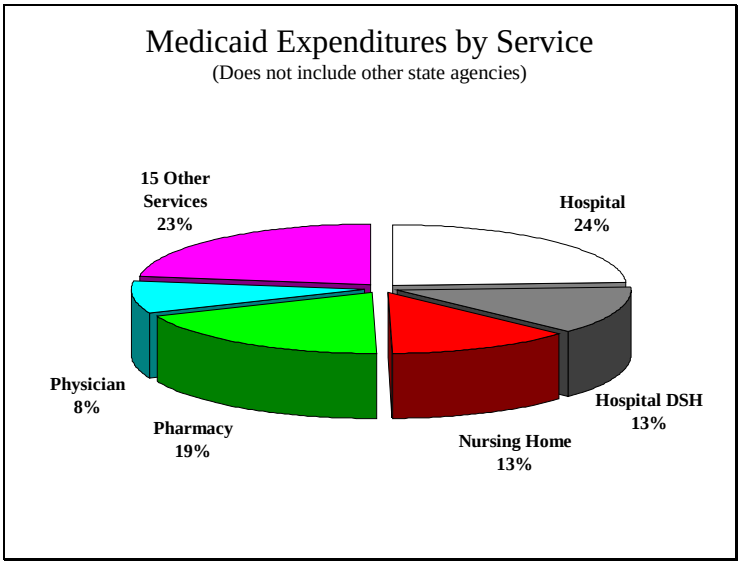
Reliance on non-recurring revenue sources to fund ongoing Medicaid services continues to be a concern for the agency. The FY 2003 budget included approximately $168 million in state matching funds from non-recurring sources. In addition, the general funds base was reduced by almost $50 million. In order to avoid reducing services to beneficiaries and/or payment of claims to providers, the agency used approximately $30 million in cash reserves to cover the shortfall created by the general fund reductions. The outlook for FY 2004 is of equal concern, with approximately $175 million in matching funds coming from non-recurring sources, and the agency's cash reserves virtually exhausted.

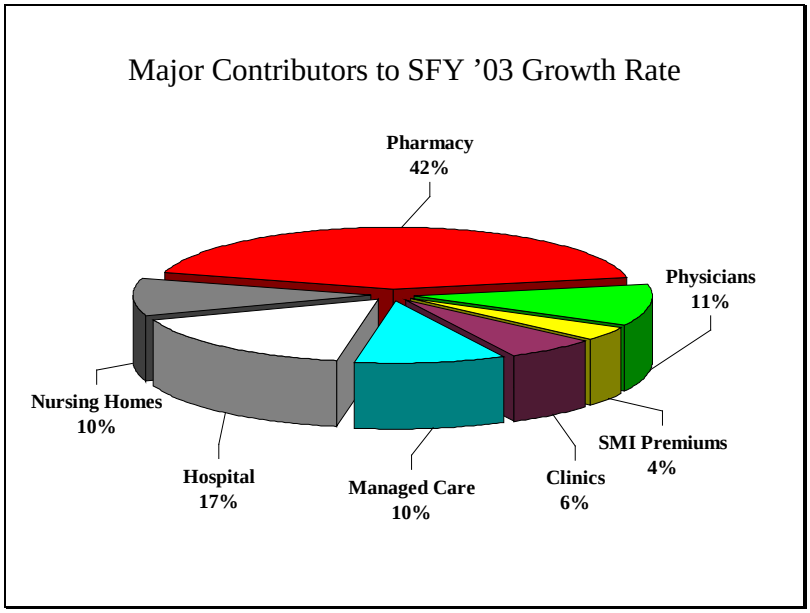
Efforts to control the cost of drugs have been delayed by additional procedural steps to satisfy Federal regulatory concerns, as well as state legislative action that exempt certain drugs from cost containment efforts. Efforts to improve eligibility processes to increase accountability will continue. Initiatives to increase the role of various models of managed care in Medicaid, combined with disease management and other preventive measures are being pursued. It is anticipated that these measures will have an impact in slowing down expenditure growth and thus improving financial performance in future years.

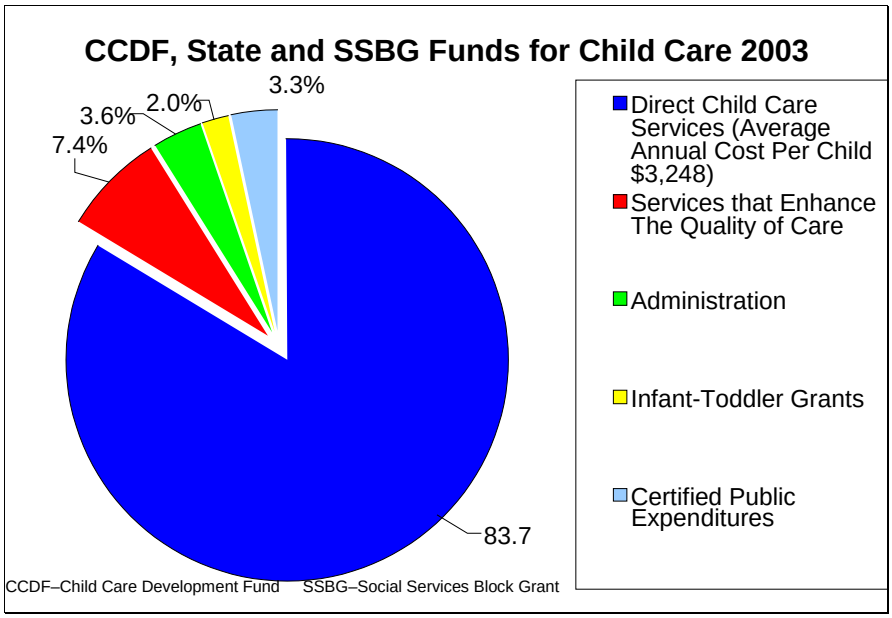

How Medicaid is Financed
Federal Funds
71%
Rebates &
Recoveries
1%
Non-state
Match
4%
State Agency
Match
8%
Hospital &
County Taxes
2%
General
Fund
14%

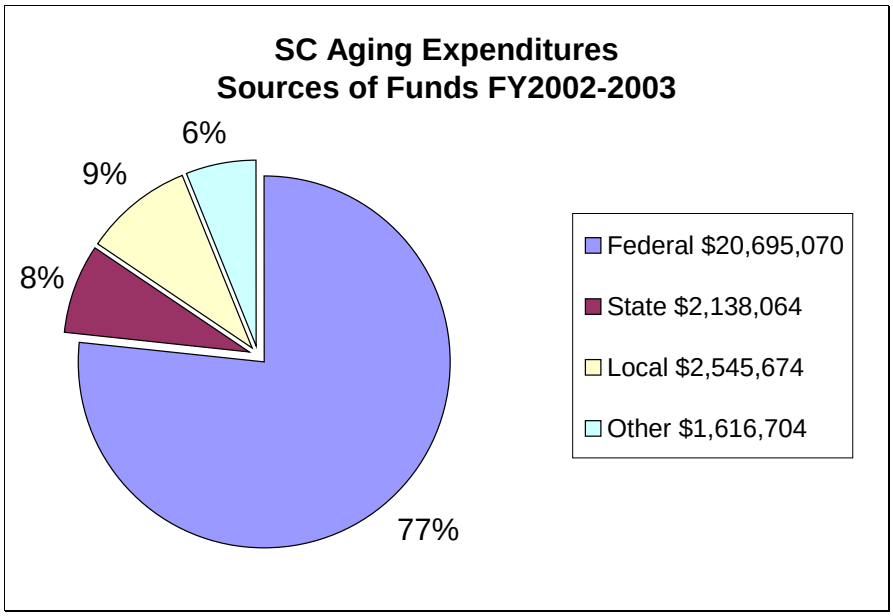

Non-Recurring vs Recurring Matching Funds
(DHHS Appropriated Funds Only)
$600
$500
$400
$300
$200
$100
$0
(in millions)
2000
2001
2002
2003
2004
SFY
Non-Recurring
Recurring

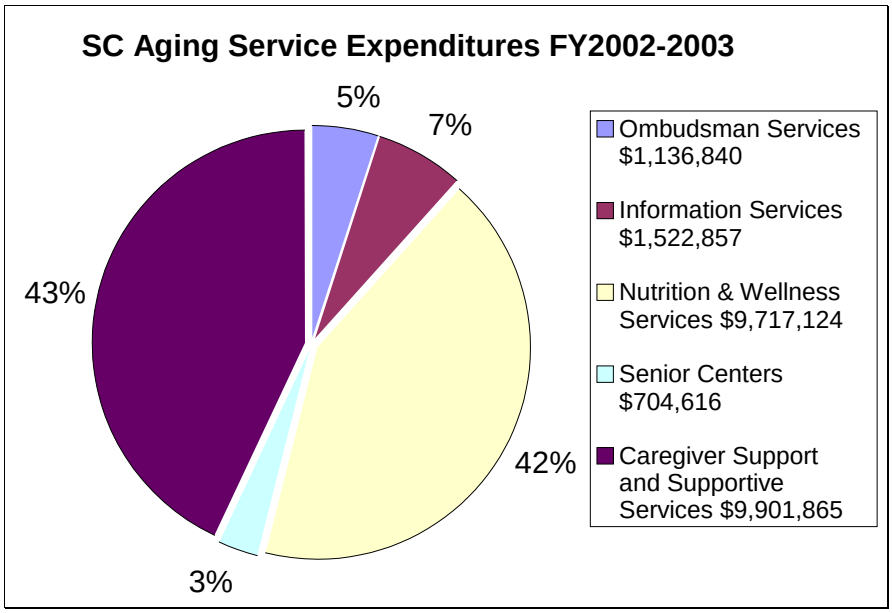

Eligibles to Expenditures by Category
Eligibles
Elderly 13%
Disabled 13%
Pregnant Women & Infants 6%
Children 31%
Low Income Families 37%
Expenditures
Disabled 41%
Elderly 23%
Pregnant Women & Infants 9%
Children 11%
Low Income Families 16%


Medicaid Expenditures by Service
(Does not include other state agencies)
15 Other Services 23%
Hospital 24%
Physician 8%
Pharmacy 19%
Nursing Home 13%
Hospital DSH 13%


Major Contributors to SFY '03 Growth Rate
Pharmacy
42%
Physicians
11%
SMI Premiums
4%
Clinics
6%
Managed Care
10%
Hospital
17%
Nursing Homes
10%


CCDF, State and SSBG Funds for Child Care 2003
3.3%
2.0%
3.6%
7.4%
83.7
Direct Child Care Services (Average Annual Cost Per Child $3,248)
Services that Enhance The Quality of Care
Administration
Infant-Toddler Grants
Certified Public Expenditures
CCDF–Child Care Development Fund
SSBG–Social Services Block Grant


SC Aging Expenditures
Sources of Funds FY2002-2003
6%
9%
8%
77%
Federal $20,695,070
State $2,138,064
Local $2,545,674
Other $1,616,704


SC Aging Service Expenditures FY2002-2003
5%
7%
43%
42%
3%
Ombudsman Services $1,136,840
Information Services $1,522,857
Nutrition & Wellness Services $9,717,124
Senior Centers $704,616
Caregiver Support and Supportive Services $9,901,865